DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45-th 7/14/13

PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to closing of corridor doors. The findings include: Observation and interview with the Maintenance Supervisor, on May 29, 2013 between 10:00 a.m. and 4:00 p.m. confirmed the following: 1. The corridor door to resident room #1 failed to close freely in its door frame. 2. The 4-bed ward (parlor) door was held open by a non-approved kickstand device. 3. The west wing smoke doors at the exit were	K 018	**K 018 NFPA 101 LIFE SAFETY CODE** 1) On 6/3/13 the Maintenance staff repaired the hinges on the corridor door to resident #1 room to allow the door to close freely. The non- approved kick stands found in the 4 – bed ward (parlor) and west wing smoke doors at the exit were removed immediately upon finding on 5/29/13. 2) The Maintenance Manager & staff checked all other resident's room doors for proper closing. No other doors were found to be needing repair. 3) To ensure that all doors work properly, door checks will be added to the monthly checks conducted by maintenance staff beginning 6/15/13.	6/14/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Weed
TITLE: Administrator
(X6) DATE: 6/14/13

An deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that c safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 held open by a non-approved kickstand device. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 018	4) Beginning 6/3/13 the Maintenance Manager will report outcomes of the monthly checks to the quarterly QAPI committee meeting and the Administrator will ultimately communicate to the Governing Body at their meetings.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barrier's fire rated construction. The findings include: 1. Observation and interview with the Maintenance Supervisor, on May 29, 2013 at 3:25 p.m. confirmed damaged grout and unsealed openings in the smoke wall above the smoke doors by room 18. 2. Observation and interview with the Maintenance Supervisor, on May 29, 2013 at 3:25 p.m. confirmed unsealed penetrations in the following areas: a. The wall in the basement corridor to the laundry room had an unsealed opening.	K 025	**K 025 NFPA 101 LIFE SAFETY CODE** 1) On 6/12/13 the penetrations identified by surveyor in the following areas – opening in the smoke wall above the smoke doors by room 18, wall in basement corridor to the laundry room, ceiling in the east linen room, kitchen ceiling to the left side of the dishwashing hood, Kitchen dry storage room ceiling were filled using fire stop caulk.	6/12/13

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			2) Maintenance Manager and staff checked other areas of the facility but did not find any more penetrations. 3) The facility's penetrations are monitored on a monthly basis in the monthly safety surveillance rounds by the Maintenance Manager and staff. All contract providers that conduct repair or installation will be given a written letter about repairing penetrations they create before leaving the facility. 4) The Maintenance Manager will report the outcomes of the penetration checks to the Administrator and to the quarterly QAPI Committee and the Administrator will ultimately communicate to the Governing Body at their meetings.	

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K 025	Continued From page 2 b. The ceiling in the east linen room. c.. Kitchen ceiling to the left side of the dishwashing hood d. Kitchen dry storage room ceiling. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to maintain hazardous areas. The findings include: 1. Observation and interview with the Maintenance Supervisor, on May 29, between 10:00 a.m. and 4:00 p.m. confirmed the following rooms larger than 50 square feet, used to store combustible materials, were not provided with door closers: a. Three basemet doors in crawlspace. b. Basement maintenance shop	K 029	**K029 NFPA 101 LIFE SAFETY CODE STANDARD** 1) On 6/3/13 door closers were installed on the following doors: a) Basement maintenance shop, b) Basement kitchen emergency storage room, c) Basement housekeeping storage room, and d) Basement linen overflow storage room by maintenance staff. Three (3) door have been ordered for basement crawl space and a door for the sprinkler room. Order date was 6/6/13 with delivery date of 6/10/13. Installation will be done by Maintenance Manager and staff with 10 days allowed	6/20/13

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			for installation and to add the door closer once doors have been installed. Completion date will be 6/20/13. A rated door was installed in the fire pump room on 6/6/13. The fire pump room headwall joint was sealed with fire caulk on 6/6/13. 2) The Maintenance Manager & staff checked other doors for needed door closers. No other doors were found to need a closer. 3) Doors have been ordered for Basement crawl space and sprinkler room on 6/6/13 and delivery is expected on 6/10/13. Installation will be completed by 6/20/13. 4) Beginning 6/3/13 the Maintenance Manager will report to the quarterly QAPI committee meeting and the Administrator will ultimately communicate to the Governing Body at their meetings.	

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K 029	Continued From page 3 c. Basement kitchen emergency storage room d. Basement housekeeping storage room e. Basement linen overflow storage room f. The west sprinkler room fire door 2. Observation, record review, and interview with the Maintenance Supervisor, on May 29, at 9:45 a.m. confirmed the fire pump room was not provided with a rated door as shown on the building drawings. 3. Observation and interview with the Maintenance Supervisor, on May 29, at 9:45 a.m. confirmed the fire pump room headwall joint was not sealed with fire caulk. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 029	**K 056 NFPA 101 LIFE SAFETY CODE STANDARD**	7/12/13
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 056	1) On 6/11/13 facility management contracted with a sprinkler company to install the sprinklers in the following areas – 1) Outside walk-in freezer, 2) the exit vestibule between the public bathrooms, 3) Below the skylight in the dining room. The estimated completion date is 7/10/13. The tamper switches on the outside valve pit will be corrected by an outside vendor and is expected to be completed by 7/12/13. (Exhibit 15)	

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			2) The Maintenance staff will inspect sprinkler valves bi-monthly and record on chart. 3) The facility's sprinkler checks will be monitored by maintenance staff to check the water flow and tamper switch. The Administrator will review the monthly surveillance logs to ensure checks of sprinkler heads are inspected for any needed repairs. An outside vendor will be used to test the Automatic Sprinkler system (valves, lines, heads, alarms and water priming levels) quarterly and every 5 years for hydrostatic test of standpipes (dry), flush pipes, calibrate pressure gauge and high temperature heads).	

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K 056	Continued From page 4 determined nsure all areas were sprinkled and had tamper switches connected to the fire alarm system. The findings include; 1. Observation and interview with the Maintenance Supervisor on May 29, 2013 between 10:00 a.m. and 4:00 p.m. confirmed the following areas were not provided with sprinkler coverage. a. Outside walk-in freezer, b. The exit vestibule between the public bathrooms, c. Below the skylight in the dining room, 2. Observation and interview with the Maintenance Supervisor on May 29, 2013 at1:00 p.m. confirmed the tamper switches on the outside valve pit were not connected to the fire alarm system. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 056	4) The Maintenance Manager will report the outcomes of the sprinkler installation and testing to the Administrator upon completion and to the quarterly QAPI Committee and the Administrator will ultimately communicate to the Governing Body at their meetings.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6 This STANDARD is not met as evidenced by: Based on observations, interview, and record review, it was determined the facility failed to maintain the sprinkler system. The findings include: 1. Record review with the Maintenance	K 062	K 062 NFPA 101 LIFE SAFETY CODE STANDARD 1) On 6/3/13 the Administrator contacted vendor who had been working with the facility on fire pump capacity. The vendor is working with the Plans Review Section of the Department of Health with this deficiency. On 5/24/13, Laurelbrook was CC'd on an email from a vendor. The email shows the vendor's	7/29/13

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			discussion with the Department of Health Plans Review. The vendor has been instructed to engage a fire prevention specialist to perform a study of the flow demand of the sprinkler system and compare it to the water demand that the pump is capable of supplying. The vendor will be here on 6/17/13. A letter will be drafted and sent to the Department of Health Plans Review to address this issue. This vendor will also repair the sprinkler head in the kitchen that was corroded and the leak at the suction side of the fire pump. A spare sprinkler head will be provided by the same vendor. Expected completion date is be 7/29/13.	

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			On 3/8/13 the water storage tank that supplies the backup water supply was inspected by the Department of Environment and Conservation. Letter of inspection is maintained in the CEO's office. (Exhibit 20) 2) The Maintenance staff will monitor sprinkler heads for water flow and tamper switch bi-monthly and record on their checklist when replacement is needed. 3) The facility's sprinkler checks are done by Maintenance staff but an outside vendor is also engaged to inspect and test per regulations.	

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K 062	Continued From page 5 Supervisor, on May 29, 2013at 1:55 p.m. confirmed there was no documentation provided to show the water storage tank, that supplied water to the fire main as a backup supply, was being maintained. 2. Record review with the Maintenance Supervisor, on May 29, 2013at 1:55 p.m. confirmed the fire pump flow test dated 4/23/13 was unable to run at 50% rated capacity. It was run at 91% capacity at 680 GPM. 3. Observation and interview with the Maintenance Supervisor, on May 29, 2013at 1:55 p.m. confirmed one of five sprinkler heads in the kitchen was corroded. 4. Observation and interview with the Maintenance Supervisor, on May 29, 2013at 1:55 p.m. confirmed the suction side of the fire pump had a steady leak at the backflow preventer. 5. Observation with the Maintenance Supervisor, on May 29, 2013 between 10:00 a.m. and 4:00 p.m. confirmed the spare head cabinet in the sprinkler riser room was not provided with sidewall sprinkler heads which were found in the facility. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 062	4) The Maintenance Manager will report the outcomes of the sprinkler head replacement and inspections to the Administrator upon completion and to the quarterly QAPI Committee and the Administrator will ultimately communicate to the Governing Body at their meetings.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined commercial cooking equipment was	K 069	**K 069 NFPA 101 LIFE SAFETY CODE STANDARD** 1) On 6/11/13 the facility management has contracted with an outside vender to add a module to the hood suppression system in the kitchen The proposed completion date is 7/12/13 (Exhibit 18)	7/12/13

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			2) The Maintenance staff will monitor the hood suppression system and record on chart. An outside vendor will be contracted to monitor and test the system per policy and regulation. 3) The facility's hood suppression system in the kitchen will be monitored by maintenance staff; Maintenance staff will check monthly to ensure it is working and no repairs are needed. This will be effective 6/28/13. 4) The Maintenance Manager will report the outcomes of the inspections and testing to the Administrator upon completion and to the quarterly QAPI Committee and the Administrator will ultimately communicate to the Governing Body at their meetings.	

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K 069	Continued From page 6 not tied to the fire alarm system. The findings include: Record review and interview with the Maintenance Supervisor on May 29, 2013 at 3:45 p.m. revealed the fire alarm service company report dated 3-26-13 stated, "Kitchen hood not tied to FACP." The Maintenance Supervisor informed the surveyor he was aware of this but it had not been corrected. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 069		
K 071 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	K 071	**K 071 NFPA 101 LIFE SAFETY CODE STANDARD** 1) On 6/5/13 self closing mechanism was installed on the laundry chute by maintenance staff and verified by Administrator and Maintenance Manager. 2) There were no other linen or trash chutes to repair. 3) Effective 6/5/13 the nursing staff will report to maintenance	6/5/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 071	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the laundry chute door was self-closing. The findings include: Observation and interview with the Maintenance Supervisor, on May 29, 2013 at 2:10 p.m. confirmed the trash chute door was not self-closing. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 071	any issues or problem with the laundry chute for repair. 4) Beginning 6/5/13 the Maintenance Manager will report any issues concerning the laundry chute to the quarterly QAPI committee meeting and the Administrator will ultimately communicate to the Governing Body at their meetings.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generators were maintained. The findings include: 1. Observation and interview with the Maintenance Supervisor, on May 29, 2013 at 11:15 a.m. confirmed the two emergency	K 144	**K 144 NFPA 101 LIFE SAFETY CODE STANDARD** 1) On 6/12/13 the facility management has contracted with an outside vender to evaluate and provide a quote to move the annunciators of the emergency generator to a continuous monitored location. The old emergency did not have documentation to show any annual 2 –hour load bank test and this will be completed by an outside vendor. The estimated completion date is 7/29/13. (Exhibit 17)	7/29/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	44E200	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/29/2013

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K 144	Continued From page 8 generators were not provided with remote annunciators located in a continuously monitored location. The new emergency generator had a remote annunciator in the mechanical equipment room and the old emergency generator was not provided with remote annunciation. 2. Record review with the Maintenance Supervisor, on May 29, 2013 at 11:15 a.m. confirmed the two emergency generators did not have documentation to show any annual 2-hour load bank test had been performed. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on May 29, 2013.	K 144	2) The Maintenance staff will monitor the emergency generators and record the checks weekly and monthly and record on log. An outside vendor will be contracted to monitor and test the emergency generator annually. 3) The facility's emergency generator is monitored by maintenance staff per facility policy and regulations. Maintenance staff will check monthly to ensure it is working as required. This was effective 6/3/13. 4) The Maintenance Manager will report the outcomes of the inspections and testing to the Administrator and to the quarterly QAPI Committee and the Administrator will ultimately communicate to the Governing Body at their meetings.	